



Dear Paratransit Applicant,

Enclosed is the certification application that you requested for Island Metro Paratransit service, the curb-to-curb alternative for people whose disabilities prevent use of Island Metro's standard fixed-flex route buses.

Please take a few minutes to read the enclosed materials that explain the program; then answer the questions regarding your abilities and limitations of using regular public transportation. You must also have your physician complete the Doctor's Certification form that you will find attached to the back of the application. Incomplete applications will delay the review process.

Upon completion of your application, please mail or return to:

Island Metro
3401 Padre Blvd. Suite C
South Padre Island, TX 78597

Faxed applications will not be accepted.

Once your application has been received, Island Metro staff will review your application. If needed, you may be contacted for more information or to arrange an interview with Island Metro Director Jesse Arriaga. Please note that Paratransit service will be provided to and from the interview upon request. It is highly recommended that if you need assistance, you should bring someone with you. We will not be able to provide assistance from the parking lot.

The process may take up to 21 days for a decision on eligibility, provided that the application form is complete and additional information is not needed. After the 21 days, if a decision has not been reached, Paratransit service will be provided on a temporary basis until a determination is made. Once a decision is made, you will be notified by letter of our determination of eligibility.

If you should have any questions regarding this application, please contact Island Metro staff at (956) 761-8175.

Sincerely,

Jesse Arriaga,
Transit Director

**Island Metro
Application
For
Paratransit Service**

What is Paratransit?

Paratransit is an alternative, curb-to-curb, reservation-required shared-ride public transportation service operating only in the South Padre Island/Port Isabel/Laguna Heights area. It is designed to “mirror” Island Metro fixed-flex route service in terms of available times and areas.

Curb-to-curb and “mirroring” provisions of ADA mean that NO assistance is provided to individuals between the door of their starting point or destination and the Paratransit vehicle. Assistance is provided ONLY to help board and exit vehicles (i.e. wheelchair lift). In addition, Paratransit is required to provide service only if both the starting point and the destination of a trip are located within ¾ mile of an Island Metro transit fixed-flex route during hours when that route is operating.

Who Qualifies for Paratransit?

Paratransit service is designed to serve ONLY those persons whose severity of disability prevents them from using public transportation. Under the Americans with Disabilities Act (ADA), disability or age does not automatically qualify a person to ride Paratransit. A person must be FUNCTIONALLY unable to use Island Metro fixed-flex route transit service. A person simply being reluctant to use the fixed-flex route because they think it is inconvenient is not a consideration in determining paratransit eligibility.

Service is provided to the following three general groups of individuals with disabilities:

1. Individuals with mental or visual impairments who, as a result, cannot “navigate the system”, or people who cannot board, ride, or disembark from an accessible vehicle “without the assistance of another individual (other than the bus driver).”
2. Individuals who need a wheelchair lift when a wheelchair lift-equipped bus is not available on the fixed route that they need to travel. (Please note: All of Island Metro transit fixed-flex route buses are wheelchair lift-equipped.)
3. Individuals that have “a specific impairment-related condition which prevents such individual from traveling to a boarding location or from a disembarking location.”

Please initial the area provided below after you have read the above information in full.

Island Metro Paratransit Application

Please answer the following questions as completely as possible. If a question does not apply to you, clearly mark N/A in the space provided.

PART I: GENERAL INFORMATION

1. Name: _____
2. Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
3. Telephone Number: Home: () _____ Work: () _____
Other: _____
4. Indicate INTERSECTION AND / OR LANDMARK _____
nearest to your home: _____
Indicate BUS STOP nearest to your home and _____
approximate distance: _____
5. Date of Birth: _____ Social Security No.: _____
6. Emergency Contact:
Name: _____ Telephone: (Home): _____
Relationship: _____ Telephone: (Work): _____
7. If someone assisted you in completing this form, please identify them:
Name: _____ Telephone: _____

PART II: INFORMATION ABOUT THE APPLICANT'S DISABILITY

9. Please check the reason(s) why you are seeking ADA paratransit eligibility.

I can use fixed-flex route buses to go some places, but not for other places. (Briefly explain.)

I can use fixed-flex route buses sometimes, but only if they are equipped with wheelchair lifts.

I can NEVER use a fixed-flex route bus.(Briefly explain) _____

10. From the following list, please check off all disabilities or symptoms that prevent you from boarding, riding or disembarking from public buses. **All areas checked off must be stated in the doctor's certification part of this application.**

General Medical Condition

- Cancer
- Diabetes
- Renal
- Organ Transplant
- Other: _____

Vision/Hearing/Speech Conditions

- Aphasia
- Cataracts
- Glaucoma
- Diabetic Retinopathy
- Visual Field Deficit
- Night Blindness
- Partially Blind
- Legally Blind
- (20/200 or worse)
- Totally Blind
- (No light perception)
- Deaf
- Deaf / Blind
- Other: _____

Heart & Circulatory Conditions

- Angina
- Congestive Heart Failure
- Edema
- Heart Surgery
- High Blood Pressure
- Other: _____

Neuromuscular Condition

- Cerebral Palsy
- Brain Injury
- Multiple Sclerosis
- Muscular Dystrophy
- Paraplegia
- Parkinson's Disease
- Quadriplegia
- Spina Bifida
- Stroke
- Vertigo / Dizziness
- Other: _____

Lung & Breathing Conditions

- Allergies
- Asthma
- Cystic Fibrosis
- Emphysema
- Other: _____

Bone & Joint Conditions

- Amputation
- Broken Bone
- Arthritis
- Osteoarthritis
- Osteoporosis
- Other: _____

Cognitive / Psychological

- Alzheimer's
Autism
Dementia
Mental Retardation
Panic Disorder
Schizophrenia
Other: _____

11. Is the disability described above: Temporary or Permanent
If temporary, how long is it expected to last?
3 to 6 months 6 to 9 months 9 to 12 months

Part III: MOBILITY AID INFORMATION

12. If you use mobility aids, check all those that apply:

Manual Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Reclining
	<input type="checkbox"/> Extended Foot Rest
<hr/>	
Motorized Wheelchair <input type="checkbox"/>	<input type="checkbox"/> Reclining
	<input type="checkbox"/> Extended Foot Rest
<hr/>	
Scooter (i.e. Amigo) <input type="checkbox"/>	<input type="checkbox"/> 3-Wheeled
	<input type="checkbox"/> 4-Wheeled

Please give the length and size of wheel base: _____

NOTE: We may not be able to accommodate you if your wheelchair/scooter is longer than 48" or wider than 32" or if your total weight with wheelchair is more than 600 pounds.

Walking Device:

- | | |
|--|---|
| <input type="checkbox"/> Folding Walker | <input type="checkbox"/> Non-Folding Walker |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Long White Cane | <input type="checkbox"/> Leg Brace |
| <input type="checkbox"/> Service Animal | |

13. Using a mobility aid or on your own, how far can you travel?
- I cannot travel outside my house/apartment
I can get to the curb in front of my house/apartment
I can travel up to 3 blocks (1/4 mile).
I can travel up to 6 blocks (1/2 mile).
I can travel up to 9 blocks (3/4 mile).

Note: A PCA is someone who is designated or employed specifically to assist the applicant with the completion of at least one daily activity on a regular basis, such as mobility assistance, personal care, eating, or communication.

14. Will a Personal Care Attendant (PCA)* be traveling with you? Yes No Sometimes

If Yes or Sometimes, please provide name of PCA and assistance being provided: _____

15. How do you currently travel? (check all that apply)

Drive myself	<input type="checkbox"/>	Island Metro Paratransit	<input type="checkbox"/>	Walk	<input type="checkbox"/>	Bike	<input type="checkbox"/>
Someone else drives	<input type="checkbox"/>	Van/Car Service	<input type="checkbox"/>	Other	<input type="checkbox"/>	Explain:	<input type="checkbox"/>
Fixed-Flex Route Bus	<input type="checkbox"/>	Taxi	<input type="checkbox"/>	_____			

Part IV: QUESTIONS ABOUT USING ISLAND METRO TRANSIT BUSES

16. Have you ever used Island Metro buses? Yes No

If Yes, how often per week?

Explain: _____

If Yes, why did you stop?

Explain: _____

If you have stopped, why is it now **impossible** and **not just difficult**, for you to travel on a fixed-flex route bus?

Explain: _____

If No, why have you never used the fixed-route buses?

Explain: _____

17. Which of the following are you able to do on a regular Island Metro bus?

Can you read a bus schedule (including TDD, tape, voice) Yes No

Can you follow instructions in an emergency? Yes No

Do you know where to get off? Yes No

Can you reach your destination when you get off the bus? Yes No

Can you get on and off a bus without a lift or ramp? Yes No

If you answered "NO" to any of the above, how does your disability make it "IMPOSSIBLE"?

18. Are you able to get to and from fixed-flex route bus stops on your own or using a mobility aid?

- I cannot if there are no curb cuts
- I cannot if road surface is uneven
- I cannot if the street or sidewalk is too steep
- I cannot cross busy street and intersections
- I get confused and cannot find my way
- I probably could with instruction
- I feel unsafe traveling alone
- I cannot recognize landmarks

If you checked any of the above boxes, please explain: _____

19. How does the weather affect your disability and limit your use of the fixed-flex route buses?

20. Can you wait 30-45 minutes for a fixed-flex route bus? Yes No

If NO, please explain: _____

21. Can you climb three 11-inch steps or find a seat by yourself without the assistance of another person? Yes No

If NO, please explain: _____

To better understand your needs, please list the three trips that you will make most frequently using Paratransit. Please list origin of trip and destination and the number of trips to that destination each week.

1. From: _____ To: _____

No. of Trips per week: _____

2. From: _____ To: _____

No. of Trips per week: _____

3. From: _____ To: _____

No. of Trips per week: _____

APPLICANT AGREEMENT FORM

I understand the purpose of this application form is to determine if I, the applicant, am eligible to use the ADA Paratransit service according to the guidelines of the American with Disability Act.

I understand that this application cannot be processed if it is not complete. I understand that Island Metro Transit Director may contact my healthcare professional/agency to verify my disability. I understand that Island Metro Transit Director may need to talk to me or see me at a later date to clarify or get further information.

I agree to notify Island Metro at (956) 761-8175 if I no longer need Paratransit for any reason, including a change in my ability to use bus service. I also understand that failure to adhere to the policies and procedures for using Paratransit may be grounds for suspending or revoking my eligibility to participate in this program.

I understand that all information will be kept confidential; only the information required will be disclosed to those who perform those services.

I understand the application process can take up to 21 days from the time Island Metro receives a complete application. If my application is returned for clarification or additional information, this can delay the process. I will receive notification of the determination of this application. If I am eligible for this service on a permanent, temporary or conditional basis, I will be notified of such.

I understand that I may appeal the determination within 60 days after receipt of written notification if I am determined ineligible for Island Metro Paratransit service or if I am dissatisfied with my eligibility type.

I understand that if Island Metro Transit Director receives new information regarding a change in my functional or cognitive ability, my eligibility status may be reviewed and changed. I certify that the information provided on this application is true and correct to the best of my knowledge. I understand that my application is subject to review and verification and that misrepresentation of any material information will lead to the revocation of my certification. I understand that a false statement made herein may result in the rejection of my application for Paratransit service.

Applicant's Signature/Mark

Date

Guardian or Person assisting with this application

Date

Relationship to Applicant

FOR OFFICIAL USE ONLY – DO NOT WRITE IN THIS BOX

Eligibility: Unconditional Conditional Temporary: (Until) Date: _____ Denied

PCA YES NO

Condition(s) or Reason(s) for Denial: _____

**PART V: AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
(MUST BE COMPLETED BY APPLICANT)**

Disability verification by a qualified professional does not guarantee eligibility for Paratransit transportation, but it can play a major role in the eligibility determination process. While verification by a physician is not required, it is important that any professional that verifies an individual's disability be familiar not only with that person's particular disability, but also with his/her ability or inability to travel on Island Metro's fixed-flex route system.

Statement of Release

I, the undersigned, understand that the medical information requested is confidential and will not be shared with any other person or agency, with the possible exception of another transit provider or transportation program to facilitate travel. I authorize the release of any and all medical records and/or information by the professionals listed below to Island Metro for the express purpose of determining my eligibility for Paratransit transportation.

Qualified Professionals

Note: Only the following professionals are authorized to verify your disability: Family physician, physical therapist, occupational therapist, O & M specialist, therapist, rehabilitation specialist, licensed social worker, registered nurse, ophthalmologist, psychiatrist, psychologist, and case manager.

Signature of Applicant

Date

PLEASE NOTE THIS APPLICATION MAY TAKE UP TO 21 DAYS TO PROCESS

Applicant's Name: _____

(PLEASE HAVE ONE OF THE FOLLOWING PROFESSIONALS COMPLETE THE REST OF THIS APPLICATION)

PROFESSIONAL CERTIFICATION

Please select from the following:

- | | | | | | |
|------------------------|--------------------------|------------------------|--------------------------|-----------------|--------------------------|
| Family Physician | <input type="checkbox"/> | Independent Specialist | <input type="checkbox"/> | Ophthalmologist | <input type="checkbox"/> |
| Physical Therapist | <input type="checkbox"/> | O & M Specialist | <input type="checkbox"/> | Psychiatrist | <input type="checkbox"/> |
| Occupational Therapist | <input type="checkbox"/> | Licensed Social Worker | <input type="checkbox"/> | Psychologist | <input type="checkbox"/> |
| Therapist | <input type="checkbox"/> | Registered Nurse | <input type="checkbox"/> | Case Manager | <input type="checkbox"/> |

Dear Professional:

The applicant who has asked you to review the information on the application and to sign this form is applying for eligibility for Island Metro Paratransit services. Please read the following information carefully since it may affect your response.

Who Qualifies for Paratransit?

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Service is provided to the following three general groups of persons with disabilities.

1. Individuals with mental or visual impairments who, as a result, cannot "navigate the system", or people who cannot board, ride, or disembark from an accessible vehicle "without the assistance of another individual (other than the bus driver)."
2. Individuals who need a wheelchair lift when a wheelchair lift-equipped bus is not available on the fixed route that they need to travel. (Please note: All Island Metro fixed-route buses are wheelchair lift-equipped.)
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CERTIFICATION

Please provide information regarding the *abilities and limitations* of the above applicant and the impact on their ability to use fixed-flex route transit services. Federal law requires Island Metro to provide Paratransit services to persons who cannot utilize available fixed-flex route bus services. The information you provide will allow us to make an appropriate evaluation of this request. Falsification of any information may result in denial of service to the applicant. Federal law also requires that we make a prompt determination in this matter.

We understand that you may only see the applicant concerning one disability, so please answer the questions pertaining to the disability you are familiar with for this applicant. Because there are sections in this application that may not apply to the applicant, it is important to make the appropriate answers only to those applicable sections, marking the section that does not apply and moving on to the next one.

Your immediate attention to this matter will be greatly appreciated. The applicant can only be considered after receiving this completed form. Thank you very much for your cooperation.

____ I do not have sufficient knowledge of this individual to offer information of their ability to use fixed-flex route transit services. *(If checked, please skip to the signature on the last page.)*

GENERAL INFORMATION

Capacity in which you know the applicant:

Identification of all condition(s) causing their limitations for safely getting to a bus stop, boarding an accessible bus (using either a ramp or one small step), and safely getting to a destination (please explain completely):

Is this condition temporary? _____ Yes _____ No
If temporary, expected duration until: _____ / _____ / _____

Is this condition episodic or occasional? _____ Yes _____ No
If yes, under what circumstances?

Does/would this condition cause the applicant to be a danger to himself/herself or others? _____ Yes _____ No

If yes, please explain.

Does/would the weather affect the applicant's disability and limit use of fixed-flex route transit services?
_____ Yes _____ No If yes, please explain.

Does/would this person *require* a Personal Care Attendant to travel with them?

_____ Yes, on all trips. He/She always needs assistance with:

_____ mobility _____ reading _____ eating
_____ transfers _____ medication _____ other: _____
_____ all of the above

_____ No, the applicant does not require assistance and may travel alone.

_____ The applicant may need assistance at times and not at others. He/She may need assistance with: _____

VISUAL IMPAIRMENTS

Does this person have a visual impairment? _____ Yes _____ No *(Note: If the applicant does not have a visual impairment, please check No and go to the next section.)*

Under what conditions is the applicant unable to independently get to and from a bus stop safely, board an accessible bus (using either a ramp or one small step), and safely get to a destination?

Vision is worse during these conditions:

- | | |
|----------------------------------|--|
| _____ bright sunlight | _____ glare |
| _____ dimly lit or shaded places | _____ sees the same in different lighting conditions |
| _____ night time | _____ no vision at all |

The eye condition is considered to be: _____ stable _____ degenerative _____ other _____

DEVELOPMENT DISABILITIES

Does the applicant have a cognitive or developmental disability? _____ Yes _____ No *(Note: If the applicant does not have a developmental disability, please check No and go to the next section.)*

Under what conditions is the applicant unable to independently get to and from a bus stop safely, board an accessible bus (using either a ramp or one small step), and safely get to a destination?

Is the person able to:

Give address and telephone number upon request?

_____ Yes _____ No _____ Sometimes

Safely and effectively travel through a crowded area?

_____ Yes _____ No _____ Sometimes

Deal with unexpected situations or changes in routine?

_____ Yes _____ No _____ Sometimes

Be aware of safety issues when traveling alone?

_____ Yes _____ No _____ Sometimes

MOBILITY DISABILITIES

Does the applicant have a mobility disability? _____ Yes _____ No *(Note: If the applicant does not have a mobility disability, please check No and go to the next section.)*

Under what conditions is the applicant unable to independently get to and from a bus stop safely, board an accessible bus (using either a ramp or one small step), and safely get to a destination?

FUNCTIONAL ABILITIES (to be completed for all applicants)

Please indicate the applicant's ability to perform the following functions:

- a. Understand directions needed to complete a trip? Yes No
- b. Identify the correct bus or transit stop? Yes No
- c. Wait standing 45 minutes outside at a stop? Yes No
- d. Wait if seated? Yes No
- e. Recognize a destination or landmark? Yes No

Would this individual *possibly* be able to safely use an accessible fixed route bus service for some trips if a person were to train the individual on riding and understanding the bus system? This includes independently getting to and from a bus stop safely, boarding an accessible bus (using either a ramp or one small step), and safely getting to a destination. Yes No

By my signature, I certify that the medical information provided in the application is accurate to the best of my knowledge and is consistent with the applicant's medical diagnosis. I understand that falsification of information may result in denial of service to the applicant. I understand all information will be kept confidential and that the applicant has a right to receive a copy of this form, if requested.

Printed Name of Professional

Signature of Professional

License Number Date

Street Address

City State Zip